John Punch, Scotist Holy War, and the Irish Catholic Revolutionary Tradition in the Seventeenth Century

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Responsibility and Well-being: Resource Integration under Responsibilization in Expert Services

Responsibilization, or the shift in functions and risks from providers and producers to the consumer, has become an increasingly common policy in service systems and marketplaces (e.g., financial, health, governmental). Responsibilization is often presented as synonymous with consumer agency and well-being. We take a transformative service research perspective and utilize the resource integration framework to investigate whether responsibilization is truly associated with well-being. We focus on expert services, where responsibilization concerns are particularly salient, and question whether this expanding policy is in the public interest. In the process, we develop a conceptualization of resource integration under responsibilization that includes three levels of actors (consumer, provider and service system), the identification of structural tensions to resource integration and three categories of resource integration practices (access, appropriation and management) necessary to negotiate responsibilization. Our findings have important implications for health care providers, public policy makers, and other service systems, all of which must pay more active attention to the challenges consumers face in negotiating responsibilization and the resulting well-being outcomes.

Keywords: responsibilization, resource integration, expert services systems, well-being, transformative service research, health care service system

> Health care providers' and health plans' expectations of patient involvement are rapidly changing. Today, sick or well, people will not benefit from their health care unless they bring to bear considerable knowledge, skills and motivation to participate actively in the care that is available to them. (Gruman et al. 2010, p. 350)

Consumers are increasingly viewed as competent, responsible, and autonomous marketplace agents (Vargo and Lusch 2008; Yngfalk and Yngfalk 2015). The conceptualization of the *responsibilized consumer* subsumes responsibilities for both personal and larger societal well-being (such as health, environmental sustainability, and poverty), to be fulfilled through consumption choices and behaviors (Giesler and Veresiu 2014). Formally defined as the shift in functions and risks from providers and producers to the individual consumer (Harris and White 2013), this neoliberal responsibilization policy holds consumers accountable for coping with market instabilities and uncertainties by building and deploying necessary capabilities (Brown and Baker 2012; Giesler and Veresiu 2014), raising issues of public interest and well-being. Responsibilization is often presented as synonymous with consumer agency and well-being. At a broad level, our research question takes a transformative service research (TSR) perspective and investigates whether responsibilization is truly associated with well-being.

Recent marketing literature has only begun to explore and point out the illusion of agency and power consumers have in the marketplace and the negative consequences of consumer responsibilization in creating "hysterical" consumers – overburdened, self-blaming, and stressed consumers (Carrington et al. 2016). What is lacking in this neoliberal view is a recognition of the structural elements in the marketplace that hinder consumer agency (Giesler and Veresiu 2014). By illuminating such structural deficiencies we explicitly explore policy and marketplace solutions to enhance consumer power and reduce the anxieties and stress accompanying responsibilization. Our core thesis in the present research is that the requisite consumer agency (i.e., freedom of choice and ability to exert the choice; e.g., Bhattacharjee, Berger, and Menon 2014) and resources for fulfilling the responsibilized consumer role are not achievable without a corresponding marketplace structure. Furthermore, we question whether, even considering marketplace structure, it is possible or desirable in terms of public interest and consumer well-being to pursue responsibilization-driven market policy.

The clash between a structurally deficient marketplace and the essentiality of consumer agency for the fulfillment of a responsibilized consumer role is particularly salient (and therefore debilitating to consumer well-being) in expert service systems. Expert service systems are those in which there is a high expertise asymmetry between providers (such as physicians, personal finance advisors, and insurance agents) and consumers. Expertise asymmetry goes beyond information asymmetry, where the provider typically has more and better information about the service exchange than the consumer (Singh and Sirdeshmukh 2000). Such systems often are comprised of a network of related, but distinct providers and complex consumption practices, access and goals needed but unavailable to fulfill the responsibilized consumer role.

The health care service system, in particular, has experienced significant shifts in both market and public policies towards responsibilized consumers, requiring patient engagement (i.e., "ordinary people managing their own health;" Laurance 2014, p. 1627) and advocating patient empowerment, reflected in calls for engaged (i.e., motivated) and enabled (i.e., capable) patients to improve health outcomes (Fumagalli et al. 2015). In spite of the positive connotations with terms such as empowered patients that should exert their agency through actively choosing treatments and providers, responsibilization forces autonomy onto health care consumers (Davies and Elwyn 2008), which in turn "ceases to promote agency" (p. 135) [1].

The positive framing of responsibilization co-opts the vocabularies of coproduction. Coproduction reflects value cocreation (Vargo and Lusch 2008) and implies partnering between providers and consumers within the capabilities, limits and preferences of consumers, but in reality (under responsibilization) demands mandatory patient activation (Hibbard et al. 2016). We see coproduction terminology used to convey responsibilization ideas and ideals in the public administration and policy literature (e.g., Fotaki 2011). Although such literature appears to refer to the same principles of cocreation of value, the connotations and philosophical underpinnings are in stark

[1] Patient empowerment is defined in the marketing literature as "the set of self-determined behaviors based on patients' individual needs for developing autonomy and competence with their disease" (Prigge et al. 2015, p. 375).

contrast between coproduction as presented in the public administration versus the service-dominant logic (SDL) and transformative service research (TSR) literatures. We use the SDL concept of resource integration (defined as "the incorporation of an actor's resources into the processes of other actors," Gummesson and Mele 2010, p. 192) as a lens to examine responsibilization and its effects on consumer well-being and SDL vocabulary (i.e., cocreation) in the remainder of the paper to refer to consumers' participatory activities and value creation in service systems.

Furthermore, given that discourse on responsibilization has co-opted coproduction and cocreation terms (e.g., Needham 2007), but not the spirit of coproduction, we illuminate the structural deficiencies preventing consumer agency in the health care service system. We focus on structure as it represents "the recurrent patterned arrangements which influence or limit the choices and opportunities available" (Barker 2005, p. 448) to resource integrators. Such patterns reflect institutional norms and logics, which can conflict within a service system and create structural tensions (Edvardsson et al. 2014). Our investigation responds to calls for taking into account the "context of context" and structural environment of consumer experiences (Askegaard and Linnet 2011; Giesler and Veresiu 2014). We therefore –in our focus on responsibilization and well-being– examine the service system as a resource integration actor (Edvardsson, Tronvoll, and Gruber 2011; Edvardsson et al. 2014).

Consumers negotiating responsibilization differ in how extensively they embrace and are capable of meeting the associated demands (Biebricher 2011). Both meeting and rejecting these demands affects consumers' well-being, reflecting subjective experiences of welfare (Kuykendall, Tay, and Ng 2015) and a continuous balancing of an individual's resources with challenges encountered (Dodge et al. 2012). We find that consumers' negotiation of responsibilization is inherently dynamic and variable, requiring an exposition of the means and strategies employed in this process. Our inquiry follows transformative consumer research principles, as we recognize both the fundamental problem of responsibilization and the complexity and contextuality of consumption experiences (Mick 2006).

By examining well-being cocreation as an enactment of resource integration within the structural elements of expert service systems, we contribute to transformative services and policy research in four ways. First, we highlight and resolve the commingling of coproduction, cocreation and responsibilization discourses. Second, we respond to recent calls for an examination of service system structures and use this frame in examining how they enable or impede consumer agency and resource integration. In the process, we contribute to the conceptualization of responsibilization by identifying critical structural tensions that arise at the intersection of responsibilization, cocreation, and policy. Third, we contribute to resource integration and responsibilization literatures by identifying resource integration practices that a consumer must undertake in responsibilization. Lastly, we develop a conceptual framework for addressing the identified structural tensions and necessary resource integration practices and discuss corresponding policy and market solutions. By doing so, we hope to provide actionable insight for both marketing and public policy researchers and practitioners.

In the remainder of the paper, we first conceptually situate the core construct of responsibilization in relation to commonly adopted vocabularies of coproduction and cocreation. We contrast the underlying assumptions and ideals of coproduction and cocreation under responsibilization vs. service-dominant logic and transformative research. Second, we develop and illustrate a conceptual framework by exploring how providers and consumers in the health care service system experience structural tensions in the system arising from responsibilization. Third, we discuss and conceptually frame emerging policy and market solutions and practices aligned with the structural tensions and resource integration practices identified. We conclude with broader implications of our theorizing and empirical illustrations for policy and market solutions across other expert service systems.

Conceptual Development: Cocreation, Responsibilization, and Resource Integration in Expert Service Systems

In order to tease apart and expose the conflicting logics of cocreation and responsibilization, it is useful to not only compare the underlying assumptions, definitions, and principles of each concept,

but do so through the lens of resource integration that is central to both and to our paper. *Resource integration* (a key concept in SDL; Vargo and Lusch 2008) refers to marketplace actors combining knowledge and skills (among other resources) to create value. Resources can be tangible and intangible, static or dynamic, and actors may own them or have access to them to deploy during resource integration (Edvardsson et al. 2014). While resources by themselves hold no inherent value, they engender potential value that can be (under the right circumstances and within a supportive service system or marketplace structure) integrated across actors in order to generate value (Edvardsson et al. 2014). While actors may have specific intentions for cocreating value from resource integration, the actual resource integration might not conform to the intentions and either enhance or destroy the value sought by the actors (Vargo and Lusch 2012). Combined, these arguments suggest that there needs to be a careful alignment between resources, activities and processes to accomplish cocreation of value between interacting actors, where their expectations, needs and capabilities are in accord. We view services as "dynamic experiences, co-constructed with customers in accordance with their views. These views may or may not entail active participation but the services are experienced regardless" (Schambri 2006, p. 386). We focus on three actors in our conceptualization: the consumer, the provider and the service system.

When viewed through this actor-centric resource integration lens (Edvardsson et al. 2014), it becomes clear that responsibilization and coproduction/cocreation espouse different logics. This difference manifests itself in two critical aspects of resource integration germane to the first actor: consumer agency and autonomy, and consumer capability.

Consumer Agency and Autonomy. Consumer agency refers to the presence or absence of choice and the locus of control in consumers' choices (Bhattacharjee, Berger, and Menon 2014). Generally assumed to be desired and appreciated by consumers, forcing choices under expertise asymmetry, as is the case with responsibilization, is stressful. In summarizing the downsides with forced choice and autonomy and policy considerations, Botti and Iyengar (2006) point out that both subjective and

objective well-being are negatively impacted. Making choices in itself increases perceptions of personal responsibility with the decision and its outcomes (Botti and McGill 2006). Therefore, when individuals are tasked to make choices and conform to the ideals of responsibilization, yet are unable to achieve the outcomes sought, because of structural tensions within a service system, this self-blame effect magnifies and induces a vicious cycle. Under responsibilization, resource integration is part of the choice and decision making processes consumers engage in as they assess consumption and service options and their corresponding norms. Not succeeding in integrating resources from their personal domain with providers and service system becomes a reflection of consumer deviance, incompetence, and inadequacy under the neoliberal logic of responsibilization (Cova and Dalli 2009; Zwick, Bonsu, and Darmody 2008; Yngfalk and Yngfalk 2015).

In vivid juxtaposition, when resource integration intentions and behaviors do not yield the desired benefits and outcomes, SDL and TSR conclude that institutional change is necessary as the regulative, normative, and cognitive norms of the service system at large are not aligned with value cocreation efforts among actors (Edvardsson et al. 2014). Rather than viewing ineffective resource integration as a failure of the consumer towards him or herself as well as society (as is the case under responsibilization; Yngfalk and Yngfalk 2015), cocreation views it as informative to and reflective of institutional logics at play.

Similarly, responsibilization provides the illusion of control, autonomy and sovereignty over resource integration, while cocreation (SDL and TSR) explicitly acknowledges the boundaries of such control. In the context of sustainable consumption, for example, consumers are presented with choices that have been carefully calibrated and assorted by companies (Firat 1996), leading to consumers being

> given the illusion of choice while both the supposed needs and desires underpinning these choices are constructed, and the choice set is strictly controlled, by marketing managers. As Smith (1987: 10) puts it rather succinctly, “consumers are not really sovereign under capitalism; they only think they are. Marketing fosters this belief.” (Carrington et al. 2016, p. 27).

That is, under responsibilization, failure to effectively engage in resource integration to create value becomes internalized, illustrating “the illusion of the consumer as a sovereign actor with the power and

responsibility to change the system (and the world!)" through resource integration choices (Carrington et al. 2016, p. 30).

In contrast, SDL and TSR logics emphasize shared accountability among all resource integration actors (Edvardsson et al. 2014; Kleinaltenkamp et al. 2014). Wider limitations on choices and consequently on resource integration are acknowledged. In the health care system, researchers are starting to recognize the negative effect of forced choices on resource integration: "Where 'autonomous' choice is imposed on an individual, the individual loses the capacity to choose a decisional role and cannot elect to be guided by professional experience" (Davies and Elwyn 2008, p. 322). In discussing the application of SDL to the health care domain, Joiner and Lusch (2016) state that transferring responsibility for making resource allocation choices is not consistent with SDL.

Consumer Capability. Related to issues of agency and autonomy, capability represents an individual's ability or competency to achieve a particular goal or fulfill expectations. Under mandatory autonomy (as engendered in responsibilization), even consumers who are assessed by expert providers as capable of making a well-informed decision might feel abandoned by the service system and provider (Davies and Elwyn 2008) and, as a result, will likely be less effective in integrating resources and cocreating value. This is especially of concern among vulnerable consumers and resource scarcity. Capability (as well as the lack of successfully exerting it) is seen as fully under the control by consumers under responsibilization. In the health care context, not meeting perceived expectations of lifestyle and treatment adherence evoke strong feelings of shame, expressions of inadequacy, and self-deprecation, all of which hinder effective resource integration during an essential interaction (i.e., the doctor-patient consultation; Guassora, Reventlow, and Malterud 2014), as patients present themselves as "responsible health agents" (p. 197) who are failing.

In contrast, under SDL and TSR logics, capability is viewed as an essential precondition to resource integration (Haase and Kleinenaltenkamp 2011), recognized to be both systemic in nature (Edvardsson et al. 2014) and uniquely experienced by individuals. Consumers' capability to be

effective resource integrators has been defined as "customers' proficiency in deploying resources as they engage in value-generating processes" (Hibbert, Winklhofer, and Temerak 2012, p. 248), driven by customer-centric learning activities embedded in and shaped by individuals' social and cultural context and values. However, not much is known about how consumers' learning activities are enacted and underpin resource integration efforts (Hibbert, Winklhofer, and Temerak 2012), particularly in complex and expert service systems. Recent clinical research suggests that the health care system can be conceptualized as a networked set of learning activities (Faden et al. 2013), encompassing not only all clinical encounters, but also various types of research and practices. The recognition that resource integration capability is not simply an issue of motivation and skill but rather a laborious and interactive set of processes and activities (Spanjol et al. 2015), acknowledges the complexities of the service system and demands a holistic examination of resource integration under responsibilization.

Expert Service Systems: The Case of Health Care. The complexities of service systems and how they come to bear on resource integration are particularly salient in expert service systems, such as health care. Consumer autonomy and capability issues buttress resource integration efforts in interactions with the second and third actors: service providers and system, respectively. Hence, examining responsibilization and how it shapes the providers' resource integration context is informative. How providers see their profession is an active and ongoing debate in health care, partially reflected in the development of and conversation around the Physician Charter (Bryan-Brown and Dracup 2003; Cassel, Hood, and Bauer 2012). The Physician Charter aims to define the fundamental principles of the medical profession –primacy of patient welfare, patient autonomy, and social justice– as a response to market forces and policies that have diminished the ability of expert providers to act in the best interest of their service users:

> …the medical profession now feels undervalued, threatened, and at times, unable to deliver appropriate care. It wishes greater influence over public policy and a health care system in which its expertise is recognized and used. Along with a loss of influence has come a well-documented loss of trust in the profession…If the profession is to have significant input into public policy (the social contract), it must be trusted. (Brennan et al. 2003, p. 851)

Effective resource integration by providers is thwarted by structural elements of the system and market grounded in responsibilization and its drive toward market-based solutions aimed at individual consumers solving societal problems (Giesler and Veresiu 2014). Perceptions of the health care system as increasingly profit driven (Bryan-Brown and Dracup 2003) and unaccommodating of professional principles can be seen in the changing definition of good practice as following evidence-based medicine (Greenhalgh et al. 2004). To improve service quality it becomes necessary to replace reliance upon professional opinion with increasingly complex clinical decision-making with statistically established, population-based treatment protocols. The market and governments use financial systems to favor certain behaviors using incentives that make it clear which treatment guidelines practitioners should follow, thus enforcing these changing norms. Apart from "concierge medicine" (where physicians take on a small number of patients in order to provide personalized and always accessible health care; Carnahan 2006), there are few options for service providers to avoid the population based model advocated by the financial controls of insurance and service payers. In fact, participation in for-profit concierge medicine services frequently bars those providers from being included in mainstream health care management contracting arrangements (French et al. 2010). Therefore, health care professionals have to comply with the financial incentives, or provide additional care without reimbursement. Non-payment signals a low market valuation for time spent building trust with patients or attempting to provide more personalized application of medical expertise. As a result, structural tensions in the service system are preventing providers from effective resource integration and cocreating valuable and meaningful benefits for their patients and themselves, including even the advocated educating of consumers to take over more responsibility:

> …a disturbing number of physicians reported that they lied to their patients…or withheld important information. This gap between the ideals espoused in the [Physician] Charter and the behavior of actual physicians is frustrating, and we believe it has many causes. First, we have a growing understanding that the systems in which physicians practice tremendously influence their professional behaviors … Physicians should not constantly have to battle perverse incentives to maintain professional values. (Cassel, Hood, and Bauer 2012, p. 291)

The resulting competing institutional logics of physicians' professional primary principle of patient welfare and that of a yield-focused responsibilization model of health care clash and induce a significant structural tension and also exemplify the differences between cocreation and responsibilization (see Appendix). In summary, given the difficulties arising from responsibilization for both consumer and provider efforts toward effective resource integration and the apparent negative well-being outcomes for these actors, our aim is to provide a conceptual framework for understanding 1) where structural tensions arise in the service system, and 2) what emerging market and policy solutions innovation might alleviate such tensions to support effective resource integration and value cocreation in expert service systems. We illustrate our conceptual framework with consumer and provider voice data.

Method

Empirical Context

We chose the health care service system related to consumers with type 2 diabetes (T2D) as the context for our research. Although responsibilization is evident across many health care and other services, consumers with chronic conditions continuously and indefinitely face demands to live up to a responsibilized consumer role, a situation that more readily exposes the effects on well-being when compared with acute health care service consumption. In addition, chronic conditions serve as an impetus for consumers to interact with many and varied providers in the health care service system, including medical professionals, insurance providers, food retailers, and exercise vendors. Market policy places the onus of diabetes prevention on the individual with or at risk of developing T2D.

Importantly, the T2D context fits with our focus on expert service systems, which we argue are particularly susceptible to negative well-being consequences due to responsibilization. We are guided by our research questions concerning resource integration efforts and experiences confronted with structural tensions in the health care service system and have consequences for consumers' well-being. To more fully comprehend the dynamics of resource integration within structural barriers and develop

our theoretical framework, we examine not only the consumer, but also the provider voice. Our approach to utilizing the data collected was guided by thematic interpretation, which was iteratively integrated with theoretical development in concert with the reading of relevant literatures. We utilize the data primarily to illustrate our resulting conceptual framework.

Data Collection and Analysis

Table 1 presents a summary of the data sources and their use to understand both the consumer and provider voices in relation to the receiving and delivering of T2D health care in a U.S. context. To capture both consumer and provider voices, we utilized publicly accessible, open discussion forums. Such online communities have been discussed as being part of the service ecosystem, representing a parallel virtual service (Laing, Keeling, and Newholm 2011) and part of the resource system both provider and consumers deploy and integrate. On the consumer side, we collected data in two online forums (American Diabetes Association [ADA] Community Support Group and DailyStrength [DS] Diabetes Forum), covering postings from January 1, 2012, to July 1, 2015. To assess the provider voice during the same time period we examined three health care professional websites (all marked as P#N; see Table 1). Our combined provider and consumer voice data resulted in more than 350 web pages of data (i.e., online postings). Other sources (e.g., published articles and editorials in medical journals) provided further insights into the provider domain and we utilize the full spectrum of the data to provide illustrative examples for the conceptual framework.

---- Insert Table 1 About Here ----

A hermeneutic analysis approach was employed (Thompson 1997) in examining the data and relating it to theory. First, an intratextual analysis was conducted on the each of the sites in order to identify key health issues of concern for T2D members. Second, we undertook an intertextual analysis to elicit rich detail within identified postings threads. At this stage in the process the most notable themes as expressed across both consumer and provider fora were gathered for thematic analysis. Finally, we linked our interpretations of the thematic analysis of consumer voices to those of the

professional voice for further consideration and comparative analysis. In keeping with our goal of capturing the world of the patient experience where "language represents the real world" (Oliver et al 2004, p. 1274) and in accordance with accepted practice, we do not correct any errors in the postings.

Structural Tensions and Resource Integration: A Conceptual Framework

Based on integrating theoretical insights from the literature and empirical data examined for this study, we develop a conceptual framework that captures structural tensions of responsibilization (thus obstructing cocreation efforts) in expert service systems, discerns emerging practices to address such barriers and identifies resource integration practices that consumers must accomplish in responsibilization. We first discuss our findings on responsibilization-induced structural tensions (experienced by both consumers and providers) that hinder effective resource integration, followed by an exposition of practices (i.e., solutions) for alleviating the identified structural deficiencies and ultimately consumers' needed resource integration practices Our conceptual framework (see Figure 1) summarizes our theorizing and empirical analysis. Our framework centers on three levels of actors in resource integration (consumer, provider and system) and incorporates our earlier discussion on competing institutional logics within the health care service system, pressures on providers and agency/autonomy and capability tensions in consumers.

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When consumers are confronted with responsibilization and engage in resource integration in expert service systems, they face the task of acquiring a multitude and highly varied sets of expertise. Yet the structure of the health care service system limits the expertise consumers are able to gain across a number of domains (e.g., expertise with the service system, disease, self-management, and others). In addition, deficiencies in capabilization (i.e., "an infrastructure of products and services that support…active self-management") mean that consumers are left without sufficient support in the form of available product and service offerings from the market to help them gain the expertise required to be effective resource integrators (Giesler and Veresiu 2014, p. 843). Overall, these institution-related

barriers limit consumer expertise and therefore consumers' success at resource integration, ultimately leading to the strong potential for reduced well-being. We spotlight structural tensions surrounding three specific resource integration practices we find required of health care consumers in order to successfully integrate resources and enhance well-being: 1) Accessing expertise for resource integration; 2) Appropriating knowledge for and about resource integration; and 3) Managing fragmented and complex service system for resource integration.

Structural Tension 1: Accessing Expertise for Resource Integration

The health care service system was built around providing expertise to health care providers and according them with what has become entrenched professional power within this expert-based service system. Not surprising with an expert service system, there are strong structures in place to train health care providers including medical schools and lengthy residency programs. This expertise allows them to write prescriptions and control not only drug access but also how readily health care consumers get access to needed devices and tools such as diabetes testing strips and lancets.

> I have to beg to get a doctor to send a refill for diabetic testing strips and lancets. I have been after one doctor for over 2 weeks to send them to my pt, and this pt tests himself regularly, but they blow him off b/c, I believe , he is Medicaid. How can someone be complaint if they don't have the tools to do so?? (P3N, nurse)

Even with more formalized training in place, health care providers themselves still struggle to have the needed expertise and may feel threatened by a more expert patient.

> What you observed… is a common occurrence that threatens the health of many diabetics and even kills some while they are in the hospital. The lack of knowledge many health care workers have about diabetes is shockingly inadequate, outdated, and often completely wrong. Diabetes is different than most diseases because patients dose their own medication and also learn how their blood sugar is affected by different variables, so the patients quickly becomes an expert in their own disease. Some physicians and nurses are threatened by that. (P4N, nurse and diabetic)

While consumers are expected to perform as responsibilized agents, requiring a multitude and highly diverse set of expertise, even when the motivation to learn is present, no formal educational structures exist. Access to resources, whether that is extra time with a health care provider to help

enhance consumer expertise or the ability to retrieve (and understand) articles published in medical journals (often behind a payment wall), are also limited. Ironically, while there is limited access to some expert sources, health care consumers have a tremendous amount of information available online including through peer-to-peer health-related forums. The substantial growth in health-related online resources is as "transformational, accelerating the shift from traditionally passive patients to patients as partners and altering the patient-health care professional relationship" (Townsend et al. 2015, p. e155). These forums work to formalize expertise and education, as best they can.

> Just want to welcome you and reiterate what others have already told you: this is the best place to hang out, learn, make friends who understand and are supportive… There is a real 'brain trust' here (I'm not one of them). To mention just a few: Alan_S, Mollythed, Lecloe, Morris Older, Mary98, and our recently passed dear friend Lizzylou. You should be able to access much of the information she shared over the years on here and in her blog & website. So, hope to 'see' you in the forum, and welcome to the T2 'family'. (ADA5)

However, trying to become informed online can prove overwhelming for some consumers. A Google search for diabetes returns over 1 billion results and a search on diabetes forums returns over 1 million results. The information available is vast in quantity but hard to judge in accuracy and source credibility, at times eliciting conflicts in discourses (Carpenter et al. 2015). Many of the online health communities lack input from those with clinical expertise even though research has shown that such input would be beneficial (Huh and Pratt 2014). This has the potential to reduce trustworthy and accurate expertise that health care consumers are able to obtain, instead leading at times to misinformed patients – a major concern for providers (Fox, Ward, O'Rourke 2005).

Structural tensions not only limit the expertise that can be gained about the disease and treatments but also reduce health care consumers' ability to gain expertise about their own self-management of their disease. In the context of diabetes, the American Diabetes Association defines self-management education (SME) as the "ongoing process of facilitating the knowledge, skill and ability necessary for diabetes self-care" (Funnell et al. 2009, p. S87). This expertise is critical for consumers to gain, which is evident to many consumers themselves:

> After my initial shock, I told myself two things: the first is that I must educate myself as much as possible on this disease, and secondly I have to do whatever I can do to try to control it…. It is the responsibility of the person with diabetes to take control of their care…. I have made it my goal in life to learn as much as I possibly can about diabetes, how my body reacts to various things, and am constantly "tweaking" my diabetes regime. (DS9)

Given that no uniform solution exists for many chronic health conditions, especially one as complex as diabetes and affected by all types of consumer behavior (e.g., food and exercise) and characteristics (e.g., overall health), it is likely that true understanding can only be gained through consumers' own experimentations with self-management techniques, regiments, and standards.

> Re: This is serious...sex b4 or after FBS????
> Exercise lowers blood glucose [Smiley emoji]. Delaying testing in the morning can give a higher number, because blood glucose may rise [Sad emoji]. You will only know how they balance out if you try testing before and after. Keep your meter on the nightstand. Be your own science experiment. Reporting the results to the forum is strictly optional [Laughing emoji]. (ADA28)

The fact that key information about self-experimentation and how to do it effectively are not routinely taught means that this is another domain of expertise that must be gained with no structure in place to help accomplish it. Scholars have recognized the power of such self-experimentation attempts (and sharing of such experiences through online communities) and the learning that it generates as reflected in a "wide range of skills and competencies . . . to make informed choices, reduce health risks, and increase quality of life" (Zarcadoolas, Pleasant, and Greer 2006, p. 55). Limits to expertise about the disease itself constrain what types of self-experimentation health care consumers may try, because their own understanding of behaviors that might impact their health will dictate what factors are the focus of self-experimentation efforts. Fragmentation within the health care system and the multiple and conflicting discourses from health care providers may also overwhelm health care consumers as they attempt this process. They may lack the ability to compare and manage the extensive amount of information coming from different sources (medical professionals, peer-to-peer forums, pharmaceutical companies, over-the-counter/direct-to-consumer marketing) to figure out what best to try and test to investigate its effects on their well-being. Research does show that health care consumers, especially those with chronic health conditions, seek out peer-to-peer help online

(approximately 1 in 4 internet users in the U.S. with a chronic illness connect with those with similar health issues online; Fox 2011). Health care consumers often turn to these other "expert" peers to gain knowledge they are not able to get from their health care professionals.

> IF we don't trigger insulin production (not eat), then our bodies eventually begin to break down the stored fat because there is less glucose available for use. (So intermittent fasting helps, too, as far as weight loss AND for both improving insulin sensitivity and decreasing insulin resistance)-- that's what the current Science says. I am hardly a medical expert. However, I have done significant review of the available research and the things I am writing are based on current research done with large populations, over years (not just a few weeks or months), in credible institutions, have been replicated numerous times, and have very good study designs to begin with. I have been utilizing this, myself, with very very good results. I have lost 35 pounds since mid-December. All of my numbers (a1c, cholesterol, triglycerides, resting blood glucose, weight) have gone down markedly. I am sharing because I hope that others will do the research themselves and consider adopting the same type of dietary regimen. Good luck! (DS12)

These self-made experts reach that status through online research, reading medical publications, self-experimentation, and experience over time. For example, Hartzler and Pratt (2011), in their analysis of patient versus clinician expertise in the context of breast cancer, found that although both sources offered information resources, knowledge, perspectives, and action strategies, the knowledge provided by patients to other patients was more experiential in nature. It focuses on issues related to "coping with highly personal issues drawn from the context of daily life" and on information "that is gained not through professional training, but rather through the trial and error of managing the lived experience of illness" (Hartzler and Pratt 2011). Although this source of information remains very important, the information can still be conflicting and the experiences of others may or may not be consistent with that of another health care consumer.

In addition, while health care consumers could, in theory, be able to experiment with eating and exercising regimens, they may be limited by associated costs (e.g., financial, psychological, time). When it comes to types of drugs and medical devices they might want to experiment with, most consumers are limited by what insurers are willing to reimburse or that they can get prescribed to them. For those without insurance, drug-based self-experimentation is almost impossible, so dietary experiments are more common.

> I feel like I keep going back and forth, as do my numbers. I have managed 85-120 without medication, if I really focus on what I'm eating.. But more times than I'd like to admit, I keep doing things I shouldn't, and that I know I will regret, just to be able to feel like I have some kind of control. I just don't feel good, at all, and it's bringing me down even more. [Sigh]. I'll work on it... I'm still trying to find someone that might help as far as medication. Having diabetes and not having medical insurance (let alone not being able to afford it) is so difficult.. I just want to be healthy, be able to take the medications I need, and just feel better... There just seems to be so many obstacles. (DS42)

There is a vast array of product, services, as well as drugs available for purchase online that are not appropriately tested or vetted that consumers might choose to use as part of self-experimentation. In a context where there is a lack of professional support and little input to help health care consumers gauge the success or the potential harm that may result from certain self-experimentation choices, there are likely to be circumstances with negative outcomes and reduced well-being.

Structural Tension 2: Appropriating Knowledge for and About Resource Integration

Due to the many challenges health care consumers face in their efforts towards responsibilization they are often going to be in situations where they lack needed expertise. This is inconsistent with expectations of the health care community, some policy makers, and even at times other consumers (e.g., family members, friends, and other onlookers) about consumers' ability to appropriate knowledge. By this we mean their ability to be able to handle vast amounts of information, turn it into expertise, and be able to be effectively deploy those resources in a way that enhances value and, in the case of health care consumers, their well-being. The health care community and social others tend to believe that because the information is out there, patients should be able to find it, understand it, and implement it. In reality, health management is not so easy.

> What sets my hair on fire: When a (nondiabetic) member of the Diabetes Police Swat Team snarkily tells everyone within earshot what I should be eating/not eating, how I could be doing a better job managing my D, etc etc - and this is more irritating because that person doesn't have the (guts) to say these things to my face. Although rarely possible, (as my alter ego/wicked persona) I'd love to set them straight, tell them exactly where their opinions belong, and wittily mention a few of their faults. I'd be wearing one of my favorite T shirts that I never get to wear: "I may be fat, but you are ugly, (substitute ignorant); at least I can diet" (ADA5)

Without the appropriation of knowledge from the experts in the health care system, consumers are less likely to succeed as resource integrators in achieving their desired well-being outcomes. In theory,

eating healthy, exercising, and managing medications in order to live longer sounds obvious. However, in practice, lifelong habits of poor diet and lack of knowledge about physical fitness, coupled with issues such as poverty (inability to afford insurance, healthy foods, gym memberships, etc.) or poor education can make it difficult to manage this disease in real life. Rather than working to understand these contextual nuances, doctors often simply disseminate information, and later, they make patients feel guilty about their lack of compliance.

> I really wanna punch my family doctor in the face. He made me an endo appointment. I'm not ready for change, sadly, and all this dam endo will tell me is shit I already know and yell at me… I'm worried the endo is gonna know about my depression. My fam doctor knows thanks to my dumbass son. I think he might tell the endo because if they ask me, which I'm sure they will, I will deny it …GETTING REALLY SICK OF PEOPLE WHO DONT CARE ABOUT ME, AKA DOCTORS, LECTUREING ME ABOUT MY SUGARS, AND I DON'T GOT TIME TO BE AT DOCTORS ALL THE DAMN TIME. (DS15)

Faced with a complex service system, differing stakeholder discourses, limited time, information overload and complexity, and a situation characterized by uncertainty and fear, consumers are faced with making many stressful decisions that may not be optimal (Berry and Bendapudi 2007). Ultimately, stress and anxiety may not only lead to but also result from poor decision-making and actions when consumers fail or fall short of their duties and obligations engendered in responsibilization.

Structural Tension 3: Managing Fragmented and Complex Service System for Resource Integration

While accessing and appropriating expertise are central barriers to effective resource integration, the fragmentation that exists within our third resource integration actor, the health care service system, especially within the United States (e.g., Stange 2009), magnifies such problems. The enormity and complexity of the health care service system and the numerous disconnected providers and other stakeholders make it difficult, for example, for patients to understand who they need to see, when they should see a particular health care provider (e.g., how long they should wait before making an appointment; which health care provider they should see first), and the process they should follow in order to see them (e.g., when they should get pre-approval from the health insurance).

Limitations imposed by health insurance policies can also add to confusion when consumers try to find health care providers and get appointments with those who are covered by their plan and distinguish what is covered from what is not covered (Gorman 2014). Various segments within the population may face added challenges that govern their experience with the health care system. Notable examples in the United States are veterans and those very vulnerable consumers who, despite the Affordable Care Act, remain uninsured. Those who are uninsured sometimes seek alternative routes to health, such as better diet, given their inability to navigate the system in the intended way.

> I tried this medication (with side effects) for two weeks... I couldn't do it. I worked full time, and couldn't afford to have the size effects come out of nowhere. Well, anyway... It has been a few months now, and I'm not sure what to do at this point. I don't have insurance to get on anything else, I have been able to test my blood sugar and it is usually around 160. :| I don't know what to do aside from eat better (which I have been, but not better enough apparently?).. I'm suppose to also be on a blood pressure medication also.. Can't take that because of no insurance, either. :((DS42)

Without insurance, consumers may be forced to seek alternative forms of health management and expertise. Without access to the advice of a physician, consumers turn to community forums—they welcome self-made or unofficial "experts," given that they cannot access professional or legitimate experts. The setup of this system is an incredibly frustrating barrier for those who are working so hard at managing and improving their own health, as prescribed by the ideals underpinning responsibilization, which are also embraced by many providers suggesting punitive consequences for those that do not perform to standards of responsibilization.

> Maybe it is time for health insurance companies to apply some of the same adjustments to those who truly don't intend to participate in their own well-being, and at the same time reward those who work hard at maintaining or restoring good health. Psycho-babble aside, there is a large contingent of the American population who will soak the system for what they can, and not take any personal responsibility. (P1N, nurse)

Given a complex network of primary care physicians, specialists, and other health care providers (from dentists to pharmacists) as well as separate testing services, each provider is likely to have a somewhat different view of the patient and not likely to share the same medical perspective, point-of-view, or opinion about treatment specifics.

> My first doctor was so conservative in treating the pre-diabetes that I was just told - go lose weight. That approach did not appeal to me - I wanted some education and guidance…. So, 3 months into the pre-diabetic lifestyle, I decided to try a different doc. Wow, what a HUGE difference. He sat and talked to me for about 20-30 minutes, he listened to my concerns, and he shared a fair amount of info with me, including that he treats pre-diabetes as diabetes (YAY I think) and he treats it aggressively. He wasn't kidding. At the end of the visit I was overwhelmed by the amount of meds he wants me to take. (ADA25)

Health care providers themselves often have limited knowledge about other providers and services that consumers also go to for care. That, in addition to short appointment times, results in health care consumers often being faced with missing, incomplete or conflicting information as they work to take steps to accomplish their health care goals (e.g., ranging from not being told to fast for a needed blood test to being prescribed expensive drugs that a health insurance provider won't cover without being told options that exist to having different doctors recommend different treatment options with different views of probabilities of various patient outcomes). Beyond these forms of disagreements, there are often discrepancies between service providers' interpretations of standards for care. For example, a hospital may have a standard in place conflicting with a specific provider's understanding of best practice.

> Our GPs have started to diagnose pts on just one HBA1c result >65mmols if the patient has no symptoms, I don't think this is right, what do you all think? …if patients have not got any symptoms we need two Hba1c >48mmols to diagnose but one Hba1c >48mmols if they do have symptoms. This job gets more confusing by the day …. There was a patient the other day who the GP had diagnosed diabetes on just one Hba1c with no symptoms, I did a further Hba1c and the second result was less than 48mmols. This confused me and the patient, the GP wasn't happy that I did a further Hba1c as I suppose this made him look silly when he had already given the diagnosis,' (P2N, nurse).

Because the system is so fragmented, with decision makers often differing from frontline providers, patients may receive mixed messages about their diseases and treatment. Additionally, this creates stress and dilemmas for physicians and nurses, who must choose between abiding by institutional procedures and rules or following their own formal training and informal experience on the job (possibly superior) and their specific knowledge of the patient. Formal systems are touted as wonderful aids to those in need, when in reality, those carrying out the service might have a different view.

> I think that part of the reason that patients are non-complaint is that they lose faith in the medical system. I can see why. Many patients who are on Medicaid are not taken seriously by health care practitioners. They are lumped into the category of "Medicaid Leach" and so, their complaints and issues go unheard. (P3N, nurse)

Tensions due to perceived incompatibility between expertise types and sources can be experienced as cognitive inconsistency (Monge and Contractor 2003) leading consumers to question the legitimacy (Tost 2011) of clinical expertise, especially when compared to patients' experiential lay expertise (Hartzler and Pratt 2011). This recurs in difficult provider-consumer relationships informed by the professional logic where clinicians hold power over patients.

The challenges health care consumers face in this regard can be considered an amplification of effects experienced by health care providers themselves. As health care providers react to pressures to reduce costs and focus on what insurance companies will reimburse, they often reduce time spent with patients limiting information that can be shared and the expertise gained by the health care consumer (Rubenstein 2012). Overall, the complexity and fragmentation of the health care system makes it challenging for consumers to gain needed expertise involving how to navigate it successfully as well as expertise they need to have related to their illness, in this case diabetes. This lack of expertise makes it difficult for consumers to orchestrate and deploy resources in a way that is expected by responsibilization and brings about the best possible well-being outcomes.

Towards More Effective Resource Integration: Understanding and Matching Emerging Solutions to Structural Tensions

Our conceptual framework highlights the challenges associated with the structural tensions to and the necessary practices for effective resource integration and well-being (see Figure 1), and provides a basis for aligning emerging solutions and policies to alleviate the respective tensions. Many innovative solutions (in the market and policy domains) leverage technology as an enabling factor in resource integration (e.g., Singaraju et al. 2016). For example, networked devices and wireless technology provide opportunities for policies such as virtual doctor visits and tele-health initiatives and for market solutions such as Apple's planned "CareKit" open-source platform to support development

of health management apps (Versel 2016). However, technology itself does not represent a solution to the structural tensions we identified and resource integration practices needed. People-based solutions are critically important in expert service systems.

In Table 2 we illustrate how emerging solutions are intertwined first between public and market policies within the health care field, and second across all three resource integration actors (consumers, providers, and service system). Market and government solutions and interventions co-exist and are inextricably linked (Stewart 2015) within the institutional field of health care – governmental policies affect the majority of market-based solutions, which in turn influence policy. Our finding of the three requisite resource integration practices (see Figure 1) provides guidance on the types of solutions that might be most appropriate to support each of these practices, and does so to a broad array of market actors, including policy makers (market and public), service organizations, regulators, and other institutions. As is evident from the table, certain emerging solutions address more than one structural tension, suggesting that policy makers and organizations might consider prioritizing investment in and development of such solutions, as they are likely to represent greater opportunity for impact. We also note the importance of alignment between different solutions and particularly those that aim to primarily enhance provider or consumer resource integration effectiveness.

Conclusions and Implications

In their inspirational "Integrated Justice Model," Santos, Laczniak, and Facca-Miess (2015) argue that companies have an ethical responsibility to jointly manage value cocreation (i.e., resource integration) with their customers, especially when consumers fall into disadvantaged segments. Fully endorsing this idea, we propose that contributing to long-term consumer well-being needs to be a core facet in the organizational goal-set. Our research can help service providers and policy makers in their efforts towards supporting more effective cocreation. Specifically, by identifying resource integration practices that consumers must engage in under responsibilization, we provide guidance on the types of solutions that are critically needed.

Policy Implications

Our research was inspired by the reality that governments and markets increasingly allocate resource integration responsibilities to consumers (e.g., through coproduction; Mende et al. 2016), and that responsibilization impacts resource integration across actors (consumers, providers, and service system). This trend stands in sharp opposition to the growing evidence that many consumers struggle to effectively enhance well-being through coproduction and cocreation, despite motivation and effort. Because of the pervasiveness of responsibilization effects on well-being, our work contains several implications that align with both market and public interest.

First, we study resource integration in the macro-context of the health care system. In so doing, we respond to recent calls for a focus on service *systems* and their effects on consumer well-being (Anderson et al. 2013). While numerous studies have examined consumers' service coproduction experiences with one provider, research that broadens the analytical lens to capture the complexities of a service system is mostly absent. We adopt such an expanded perspective and are (to the best of our knowledge) first to investigate resource integration by contrasting the logics of cocreation (proposed in the marketing literature) and responsibilization (proposed in the governmentality literature). Our analysis suggests that responsibilization (in juxtaposition to cocreation) creates three significant structural tensions (i.e., access, appropriation, and management of expertise and resources) that prevent effective resource integration within expert service systems across actors (i.e., consumers, providers, and service system). By identifying these structural tensions and corresponding resource integration practices, and advancing the conceptualization of responsibilization, we hope to stimulate further research in this domain.

Second, we have focused marketplace and government policies of responsibilization in health care, which mandate that consumers must make responsible choices and "manage their lifestyles so as to promote their own health and well-being" (Clarke 2005, p. 451). Notably, health care is not the only service context in which responsibilization occurs. Various governments encourage (or urge) their

citizens to take responsibility for their diet and weight (Kirkland 2011), their physical fitness (Wiest, Andrews and Giardina 2015), and their financial security (Williams 2007). Given the ubiquity of responsibilization, our research was possibly a rather conservative assessment of responsiblization effects, because we only investigated one sector. There are likely additive (if not multiplicative) effects of responsiblization across often interrelated service sectors (e.g., health care and financial services). In other words, the effects of responsibilization on consumer well-being might be more profound and severe than our findings imply, a concerning notion that deserves more scholarly attention.

In addition to the just-mentioned public interest and marketplace implications, responsibilization might have consequences that were unintended by policy makers and the marketplace. For example, popular media and medical literature increasingly blame parents for childhood obesity (e.g., Lupton 2011). That is, parental food choices are portrayed as free decisions, while discounting the fact that –at last partially– changes in the food industry (e.g., higher calorie levels, larger portion sizes, marketing efforts), are also major drivers of (childhood) obesity. More generally, the neoliberal lens of responsibilization suggests that "responsible citizens make reasonable choices – and therefore 'bad choices' result from the willfulness of irresponsible people, rather than the structural distribution of resources, capacities and opportunities" (Clarke 2005, p. 451). We believe that scholars at the intersection of marketing and public policy are uniquely qualified to contribute to a deeper understanding of (dis)advantages linked to the idea of responsibilization, particularly relative to alternative paradigms in marketing (e.g., SDL's coproduction). Especially because (a) responsibilization has received little scholarly attention in the service literature, and (ii) it is an increasingly omnipresent phenomenon in consumers' lives, it needs to be studied by consumer researchers.

Third, we recommend that service organizations, potentially in collaboration with or supported by policy makers, segment consumers on the basis of their service (system) literacy and customize the coproduction experience. Recall that consumer autonomy/access and capability are cornerstones of

successful resource integration. Against this background, modern technologies, such as the concept of gamification (Maynard et al. 2012), can be powerful tools: service systems could create "coproduction games" that boost consumer autonomy and capability in a customized manner (i.e., games could be played on smartphones and would self-adjust to the focal player's abilities).[2] Such coproduction games are not only always accessible, but they can also be one way to provide encouragement to consumers. From an organizational perspective, coproduction games are cost-efficient and allow service systems to (potentially) share data about consumers in order to improve their coproduction experience. Finally, such technology would also help with building credibility through certifications that players earn (recall our insights about the lack of credibility in peer-to-peer networks). For example, Jane McGonigal's "SuperBetter" game has garnered widespread attention as a vehicle for alleviating anxiety and depression and enhancing personal resilience. Public interest implications might include the provision of research grants towards gamification solutions for effective resource integration.

However, it is evident that the above aspects suggest that service organizations in the 21st century need to consider new forms of inter-organizational collaboration (between for-profit and non-profit organizations, policy makers, and consumer/peer-to-peer networks, etc.). Such collaborations might result in the creation of new certifications (e.g., expert patient designations and courses that include regulated certification courses and programs).

Finally, policy makers may examine the incentives that motivate resource integration actors (i.e., consumers, providers, and service system) identified. One way toward aligning the various incentives in the long-run would be for policies to incorporate a focus on consumer well-being into the expert-generating systems; that is, into the educational systems that produce service professionals. For example, educational curricula (e.g., in medical and business schools) could include courses on

[2] For example, *Doorways to Dreams Fund* (which focuses on vulnerable, low-to-moderate income households) uses the video game 'Financial Entertainment' to build the financial capability of its clients; initial evidence suggests that this game successfully engages consumers, helps cultivate financial literacy, and positively affects financial decisions (Maynard et al. 2012). Games like this, while not applicable to every service and consumer, could form the basis for corresponding coproduction games in financial services, health care, and other well-being settings.

consumer well-being and responsibilization, so that future service professionals and managers are trained –from the onset of their careers– to attend to well-being at the consumer, provider, and more general service system level.

Limitations and Future Research

We acknowledge that our work –while based on extensive theorizing and drawing on observational data– has as its major limitation the empirical focus on one single industry. While Type 2 Diabetes specifically, and the health care system in general, provides for a rich examination of the conceptual issues around responsibilization, resource integration, and well-being, other service domains are equally important to study. As such, future research is ripe with opportunities in understanding the scope and the depth of the arguments presented in the present paper.

Within the general service context, a myriad of industries are faced with both the expectations of and lack of clarity towards responsibilization in the service script (e.g., retirement and financial services, higher education). The cornerstones of consumer agency/autonomy and consumer capability can guide such research efforts. Naturally, these concepts relate to research on consumer expertise, defined as the ability to perform consumption-related tasks (Alba and Hutchinson 2000), or research on various forms of consumer literacy (e.g., financial literacy, media literacy, medical literacy; e.g., Lusardi and Mitchell 2008; Peerson and Saunders 2009). However, studying resource integration in the context of service systems likely requires a more macro-perspective, which is (among other things) reflected in new constructs. For instance, medical literacy has been conceptualized as a consumer's ability to perform reading and numerical tasks required in a health care environment (Baker 2006; Peerson and Saunders 2009). It is easy to imagine that a consumer has high levels of this medical literacy, yet still struggles with successful resource integration because of the system-related tensions identified in our research. In other words, most of the constructs that services marketing scholars frequently study do not capture the full scope of consumers' experiences and result in considerable conceptual voids in extant theories. Therefore, new constructs (and corresponding measures and/or

indicators) are needed. Examples include consumer 'service *system* literacy' or –on the flipside– *system-derived* consumer fatalism, coproduction overload, or consumer burnout due to their resource integration experiences with service systems (analogous system-level constructs on the service provider's side are equally relevant). Incorporating these novel facets into existing conceptual models of service coproduction would be a major step forward.

Future work is also needed to empirically evaluate the strategic solutions presented in navigating the complexities of critical service systems, as well as measure consumer's service (system) literacy for the ultimate increased well-being for all involved stakeholders. Within both the health care industry, as well as other service sectors, the motives of policy makers, business entities, and consumer advocates must align for the collective benefit and overall health of the service system. Selected strategies must be observed holistically, understanding both the benefits and detriments that all opportunities suggest. Policy researchers should continue to evaluate how proposed solutions to stakeholder tensions will help to alleviate the burden of responsibilization, instead fostering an environment of collaboration and shared knowledge and resource integration for higher order co-created relationships and optimal service delivery.

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Table 1: Types of Data Sources

Source	Type	Purpose of Usage
1. American Diabetes Association (ADA) Community Support Group (http://community.diabetes.org)	Consumer: Online forum	Capture consumers' lived experiences of type 2 diabetes.
2. DailyStrength (DS) (http://www.dailystrength.org/c/Diabetes-Type-2/support-group)	Consumer: Online diabetes forum	Capture consumers' lived experiences of type 2 diabetes.
3. All Nurses: Patient non-compliance thread (http://allnurses.com/nursing-activism-healthcare/patient-non-compliance-16387.html)	Provider: Online nurses forum	Gain insight into how providers of type 2 diabetes care discuss the concept of responsibilization.
4.Practice Nursing: Hba1c again thread (http://www.practicenursing.co.uk/forum/topic.aspx?TOPIC_ID=24770&whichpage=-1)	Provider: Online practice nurses forum	Capture lived experiences of providers (nurses).
5.All Nurses: Mismanagement of diabetes thread (http://allnurses.com/diabetes-endocrine-nursing/mismanagement-of-diabetes-904850.html)	Provider: Online practice nurses forum	Capture peer to peer discussions of providers (nurses).

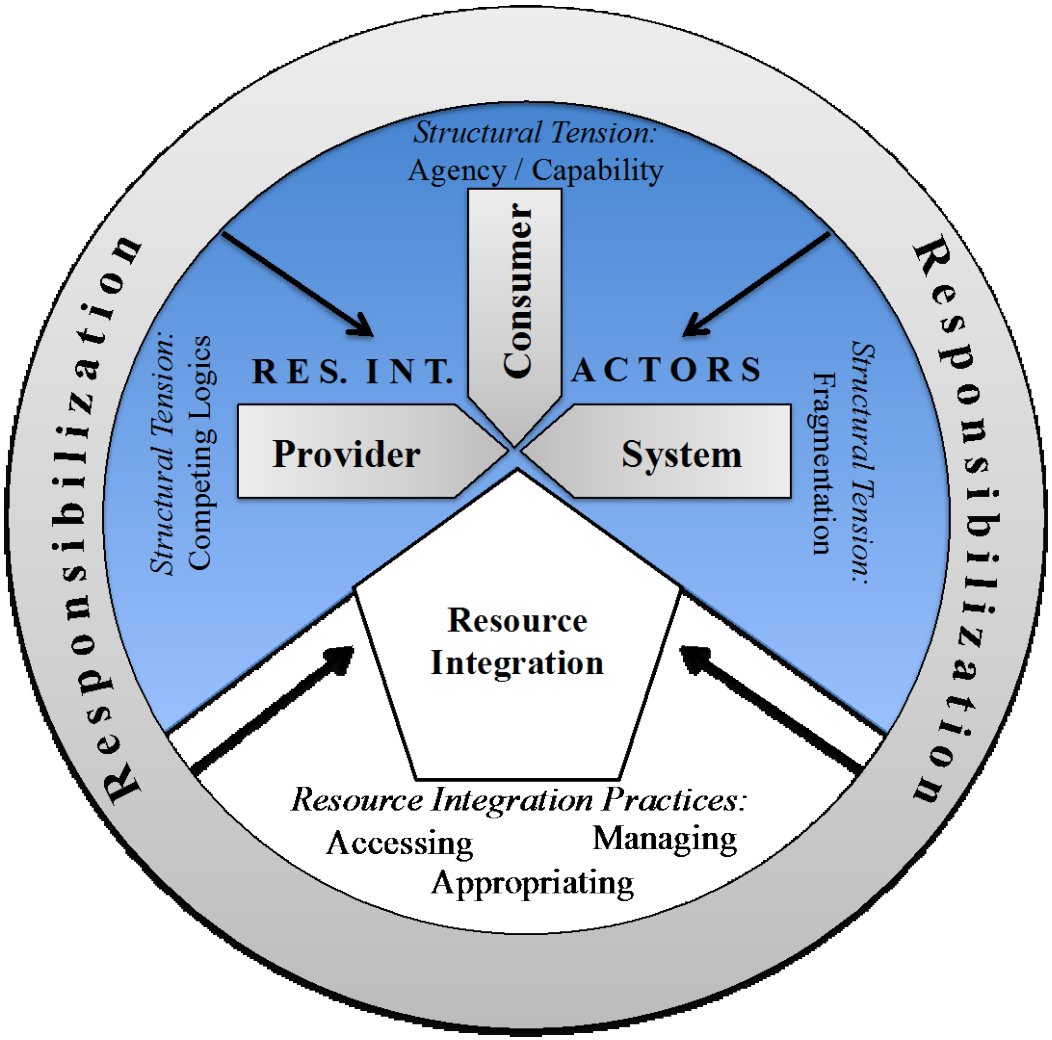
Table 2: Selected Emerging Solutions Addressing Structural Tensions (Panel A)

Emerging Solutions C=consumer / P=provider / S=system focused	**Structural Tensions Related to Responsibilization**		
	Accessing Expertise for Resource Integration	*Appropriating Knowledge for and about Resource Integration*	*Managing Fragmented and Complex Service System for Resource Integration*
Note that most solutions can originate from either the market or governmental initiatives (see Stewart 2015).	Clinical Pharmacist (C, S) Community Health Worker (C, S) Health Data-sharing Platform (C, S) Health Management App (C, P, S) Research Institutes / Agencies (S)	Clinical Pharmacist (C, S) Health Coach (C) Health Data-sharing Platform (C, S) Health Management App (C, P, S) Knowledge Broker (P, S) Research Institutes / Agencies (S)	Community Health Worker (C, S) Crowdsourcing Diagnosis (C, S) Health Data-sharing Platform (C, S) Knowledge Broker (P, S) Research Institutes / Agencies (S)

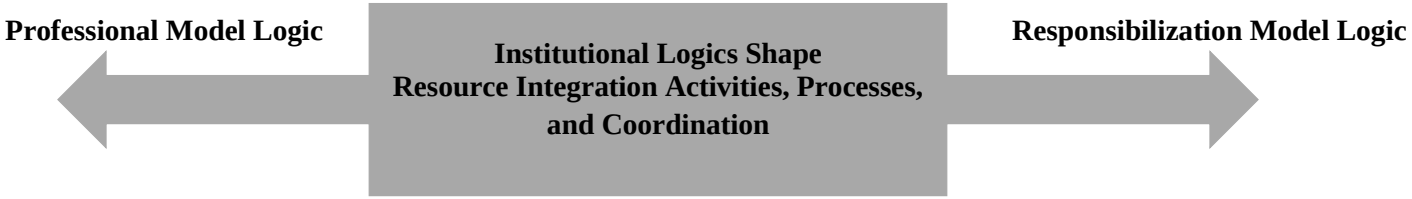
Table 2: Selected Emerging Solutions Addressing Structural Tensions (Panel B)

Brief Descriptions of Exemplar Solutions: (in alphabetical order)	
Clinical Pharmacist	Clinical pharmacists' cabilities and expertise go beyond those of community pharmacists. They can review medication prescriptions, adjust prescriptions, support patients, assess barriers to treatment adoption, etc. As such, they can provide clinical expertise and time that a physician might not have. Yet, they are vastly underutilized in the service system. One of the main reasons is that physicians don't refer patients to clinical pharmacists (Misita 2015) – i.e., the system is not set up to take advantage of such a solution.
***Community Health Worker* (CHW)**	CHWs are an underutilized provider category. They facilitate access to expertise and other resources in the service system for consumers. They are particularly helpful in bridging the divide between provider and consumer in the service system so important to effective resource integration. While CHWs are lay personnel, they command significant context expertise on both the provider and consumer sides, so they can also "heal" some of the fragmentation (see structural tension #3) within the system. Calls for the growth of community health worker programs have pointed out the cost-effectiveness of these boundary spanners as they allow "health systems with limited resources to invest in a single scalable model, rather than choosing among disease-specific programs (Kangovi, Grande, and Trinh-Shevrin 2015, p. 2278).
Crowdsourcing Diagnoses (e.g., crowdmed.com)	For consumers who have been struggling to benefit from repeated and prolonged access to the medical service system (resulting in a lack of effective diagnosis and treatment), crowdsourcing of diagnoses for difficult and complex medical cases offers potential relief (for example, see crowdmed.com). By bringing together varied teams of providers to examine a medical case, the challenge of navigating a fragmented system of specialty physicians is addressed.
Health Coach	Shared decision making requires health care consumers to be capable to assess, process, evaluate, and determine highly complex information, and do so in light of highly variable personal contexts (see Groopman and Hartzband 2011). To help with absorbing and appropriating expertise for resource integration, health coaches (i.e., certified medical assistants) provide a possible solution. Health coaches act as information translators, discussion facilitators with other providers, advocate, decision and behavior planning aide, and facilitators of service system resources and coordination (Thom et al. 2014)
Health Data Sharing Platform	Online platforms that bring together consumers with providers and/or researchers in order to enhance learning and improve experiences and outcomes. Patientslikeme.com, for example, provides researchers and firms access to patient self-report data and tools for patient stories to be translated into measures, as well as active recruitment of patient input into research teams for new health measures. Clinicians can also use the site to track their patients. The site provides both consumer-to-consumer and consumer-to-expert interaction. Other sites (e.g., smartpatients.com) aim to provide peer-to-peer support, access to latest clinical research and clinical trials.
Health Management App	Mobile apps have proliferated and are addressing many different problems in the health care and management domain. Mostly consumer-oriented, the importance of mobile platforms for health care services is evidenced by the significant investment of companies like Apple and Google. For example, Apple's "Care Kit" provides an open source platform for development of health management apps.
Knowledge Broker	To facilitate the often complex and distributed care needed, knowledge brokers are emerging as a solution aimed at overcoming fragmentation and enhancing resource integration on the provider side. These team members engage diverse activities: "information management (helping teams find, package and disseminate information), linkage and exchange (facilitating discussions between the teams and relevant experts) and capacity building (helping teams develop their capacity to exchange knowledge into the future)" (Ward et al. 2012, p. 298).
Research Institute / Agency	Research institutes and agencies that focus on integrating consumers into research study design explicitly can address all three structural tensions by adopting a holistic approach to generating and comparing clinical solutions. One such federally-funded research agency is PCORI (Patient-Centered Outcomes Research Institute), founded in 2010, that requires all research projects to engage patients, caregivers, providers, and communities. See www.pcori.org.

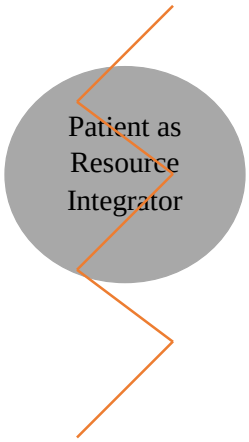
Figure 1: Responsibilization and Resource Integration in Expert Service Systems



Appendix: Competing Institutional Logics in Health Care Provider Domain



- *Primacy of patient welfare principle*
- *Provider expertise focused on individual patient needs*
- *Ethical constraints to supporting redistribution of expertise to non-professionals*
- *Maintenance of large expertise differential is a matter of self-interest*
- *Resistant to non-professional forms of phenomenon expertise because it interferes in the relationship of trust between professional and patient*



- *Centrality of illusory patient autonomy principle*
- *Availability of provider expertise constrained by what will be reimbursed*
- *Cost-efficiency and volume throughput approach in streamlined provision of evidence-based care only for improved distribution of scarce resources (i.e., population-based approach to care)*
- *Practical constraints to supporting redistribution of expertise to consumers for improving practice of preventative self care*